



FOR OFFICE USE ONLY:	
Accepted: ___ / ___ / ___	Verified by: _____
STATUS: _____	L/SCAN DATE: _____
COMMENTS: _____	

PROVIDER APPLICATION FORM

SOCIAL SECURITY NO.: _____			
FIRST NAME: _____		MIDDLE INITIAL: _____	
LAST NAME: _____			
HOME PHONE: (209) _____		CELL PHONE: _____	
MESSAGE PHONE: _____		PAGER: _____	
PHYSICAL ADDRESS: _____	_____	State: CA	Zip: _____
MAILING ADDRESS: _____	_____	State: CA	Zip: _____
DATE of BIRTH: _____	GENDER (Optional):	<input type="checkbox"/> Male	<input type="checkbox"/> Female
PROOF of IDENTIFICATION:	<input type="checkbox"/> CA ID#:	Expiration Date: _____	
	<input type="checkbox"/> CA DL#:	Expiration Date: _____	
	<input type="checkbox"/> Passport #:	Expiration Date: _____	
	<input type="checkbox"/> Other ID:	Expiration Date: _____	
PROOF of AUTO INSURANCE: (Insurance Agency/Broker Name) _____		Expiration Date: _____	
DMV PRINT-OUT: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (IP does not drive)			

DAYS and HOURS of AVAILABILITY: (Check all that apply)

Mornings:	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
Afternoons:	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
Evenings:	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
Overnight:	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun

Number of hours you would like to work: **CIRCLE ONE = per week OR per month**

<u>IP CHARACTERISICS</u>		<u>CONSUMER PREFERENCES</u>	
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work for a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Form of transportation?	<input type="checkbox"/> Bus/Transit <input type="checkbox"/> Car	Live-in position?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Read/Write English?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Client preference:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either
Will you use a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drive client's vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infectious Diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work for clients w/ pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Willing to work: <input type="checkbox"/> Holidays <input type="checkbox"/> Overnight <input type="checkbox"/> On-Call <input type="checkbox"/> 1 – 2 Hours <input type="checkbox"/> Private Pay			

GEOGRAPHIC PREFERENCE:

<input type="checkbox"/> Altaville	<input type="checkbox"/> Dorrington	<input type="checkbox"/> Mountain Ranch	<input type="checkbox"/> Valley Springs
<input type="checkbox"/> Angels Camp	<input type="checkbox"/> Douglas Flat	<input type="checkbox"/> Murphys	<input type="checkbox"/> Wallace
<input type="checkbox"/> Arnold	<input type="checkbox"/> Glencoe	<input type="checkbox"/> Paloma	<input type="checkbox"/> West Point
<input type="checkbox"/> Avery	<input type="checkbox"/> Hathaway Pines	<input type="checkbox"/> Railroad Flat	<input type="checkbox"/> Wilseyville
<input type="checkbox"/> Burson	<input type="checkbox"/> Jenny Lind	<input type="checkbox"/> Rancho Calaveras	<input type="checkbox"/> OTHER
<input type="checkbox"/> Camp Connell	<input type="checkbox"/> Milton	<input type="checkbox"/> San Andreas	[Outlying County areas, for example: Sheep Ranch, Tamarack, White Pines, etc.]
<input type="checkbox"/> Campo Seco	<input type="checkbox"/> Mokelumne Hill	<input type="checkbox"/> Vallecito	
<input type="checkbox"/> Copperopolis			

TYPE of WORK DESIRED:

<input type="checkbox"/> Accompaniment to Alternative Resources (taking Consumer to & from appointments where they receive services in lieu of IHSS)
<input type="checkbox"/> Accompaniment to Medical Resources
<input type="checkbox"/> Ambulation (assisting with walking, or with moving from place to place)
<input type="checkbox"/> Bathing/Oral Hygiene/Grooming (includes "stand-by assistance")
<input type="checkbox"/> Bowel/Bladder Care (external appliances only)
<input type="checkbox"/> Care & Assistance w/ Prosthesis; Medication set-up (assistance w/ medications)
<input type="checkbox"/> Domestic Services (Clean floors, wash kitchen counters, stoves, refrigerators, bathroom; store food, supplies; take out garbage; dust, pick-up; bring in fuel; change or make bed; and miscellaneous.)
<input type="checkbox"/> Dressing
<input type="checkbox"/> Feeding
<input type="checkbox"/> Heavy Cleaning* (authorized 1x/mo. only)
<input type="checkbox"/> Meal Clean-up
<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Menstrual Care
<input type="checkbox"/> Moving In/Out of Bed
<input type="checkbox"/> Other Shopping & Errands
<input type="checkbox"/> Protective Supervision (keeping Consumers safe from harming themselves or others)
<input type="checkbox"/> Respiration
<input type="checkbox"/> Routine Bed-baths
<input type="checkbox"/> Routine Laundry (Includes routine ironing)
<input type="checkbox"/> Rubbing Skin; Re-positioning; etc.
<input type="checkbox"/> Shopping for Food

WILLING to WORK WITH:

<input type="checkbox"/> Adults
<input type="checkbox"/> Alzheimers
<input type="checkbox"/> Children
<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Elderly
<input type="checkbox"/> Infectious Diseases
<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Men
<input type="checkbox"/> Mental Health Issues
<input type="checkbox"/> Parkinsons
<input type="checkbox"/> Quadriplegics
<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Women

YOUR ETHNICITY: (Optional)

<input type="checkbox"/> African-American	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Latino	<input type="checkbox"/> OTHER

LANGUAGES:			PRIMARY LANGUAGE: (Pls. identify)
<input type="checkbox"/> American Sign <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German	<input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog	<input type="checkbox"/> OTHER [Please specify] _____	<input type="checkbox"/> _____

<p>Do you have any felony criminal convictions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "YES", convicted of: _____ _____</p> <p>Felony conviction date/s: _____ _____</p> <p>Case disposition: _____ _____</p>	<p>Have you ever used illegal drugs or alcohol in a work setting? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please explain: _____ _____</p> <p><input type="checkbox"/> I <u>have had</u> drug and alcohol problems: Please explain: _____ _____</p>
<p>Do you give the Registry permission to conduct a background check? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

TRAININGS and CERTIFICATIONS

List any training you have had related to care-giving or in-home care:								
List any certificates or licenses you possess:								
<table style="width:100%; border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> First Aid</td> <td style="border: none;">Expires: ____/____/____</td> <td style="border: none;"><input type="checkbox"/> CNA</td> <td style="border: none;">Expires: ____/____/____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> CPR</td> <td style="border: none;">Expires: ____/____/____</td> <td style="border: none;"><input type="checkbox"/> CHHA</td> <td style="border: none;">Expires: ____/____/____</td> </tr> </table>	<input type="checkbox"/> First Aid	Expires: ____/____/____	<input type="checkbox"/> CNA	Expires: ____/____/____	<input type="checkbox"/> CPR	Expires: ____/____/____	<input type="checkbox"/> CHHA	Expires: ____/____/____
<input type="checkbox"/> First Aid	Expires: ____/____/____	<input type="checkbox"/> CNA	Expires: ____/____/____					
<input type="checkbox"/> CPR	Expires: ____/____/____	<input type="checkbox"/> CHHA	Expires: ____/____/____					
How many years of experience providing in-home care do you have?								

REFERENCES

[Provide a minimum of 2 employment, and 1 personal. Do not use relatives, please.]
<input type="checkbox"/> Employment 1. NAME: _____ PHONE #: _____ MAILING ADDRESS: _____
<input type="checkbox"/> Employment 2. NAME: _____ PHONE #: _____ MAILING ADDRESS: _____
<input type="checkbox"/> Personal 1. NAME: _____ PHONE #: _____ MAILING ADDRESS: _____

Criminal Background Checks on IHSS Providers - - Current law states, In-Home Supportive Services (“IHSS”) Consumers (the employer of IHSS Providers) and the Public Authority:

Have the legal right to conduct Department of Justice (DOJ) criminal background checks on current Providers or Providers they are considering hiring.

May decide not to hire or retain Providers who refuse to complete background checks.

May decide not to hire or retain Providers based on the results of background checks.

Must protect the confidentiality of the results from DOJ background checks.

I understand that fingerprinting may be done through the Public Authority for the purpose of a DOJ criminal background check. I further understand the results may be shared with my potential employer, the IHSS Consumer.

I am willing to be fingerprinted for a DOJ background check: **YES** **NO** **Initials:** _____

Further, regarding this application to participate on the Provider-Consumer Registry:

I certify under penalty of perjury that all the information provided in this application and its related process is true. I understand that any false information may eliminate me from eligibility for participation on the Provider-Consumer Registry.

I understand that my name may be placed on a list to be given to persons who are seeking assistance in their homes, without further notice.

I understand the Public Authority retains the exclusive right to list, refer with or without comment, suspend, or remove an individual Provider from the Registry.

I understand that Registry staff will conduct a background check on me using publicly available resources.

I understand that the information on this questionnaire may also be shared with prospective employers and their advocates without further notice.

I understand completing this application and being listed on the Registry **does not guarantee me employment.**

I understand that my employer is **not** Calaveras County In-Home Supportive Services (“IHSS”) or the Calaveras County IHSS Public Authority. **The IHSS Consumer is my employer.**

I further understand that an IHSS Consumer-Employer retains the exclusive right to hire, supervise, and terminate my employment with or without cause.

I understand that I may by written request, ask that my name be deleted from participation on the Provider-Consumer Registry.

Signature: _____ Date: _____

Print Name: _____

Remember to call the Registry to update your availability, phone number, and address whenever there is a change. If you do not, you will be **made inactive** and your name **will not** be referred to IHSS Consumers.